



Health Education and Health Promotion Skills of Health Care Professionals Working in Family Health Centres

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ABSTRACT

Preventable diseases pose a serious problem worldwide. The role of primary healthcare professionals is especially significant in promoting health. **Aim:** It is aimed to determine the health care professionals working in family health centres have on health education and health promotion skills. **Method:** The study sample included 144 health care professionals employed in one of 33 family health centres in Ankara Province. The study data were collected using a survey developed on the health education and health promotion skills included in the family medicine specialty education and curriculum from 2008. **Results:** It was found that 33.3% of the health care professionals had planned to receive health education, and that approximately half of the health care professionals had actively practiced health education and health promotion skills. Considering that time constraints were reported to be the most significant barriers to health promotion, primary health care professionals, most particularly the nurses, should be provided with comprehensive continuing educative training on health promotion and health education skills to foster their professional development. Health promotion and health education trainings shall serve to help them become more active and take on the responsibility of assuming counselling and training roles in health education.

Keywords: Health education, health promotion, family health centre, health professionals

INTRODUCTION

Health promotion is generally defined as the process by which individuals increase control over their health and enables achieving an optimal level of health [1,2]. The foundations of health promotion are based on health education, and the declaration of Alma-Ata (Almaty) addressed the education of society about common health problems, their prevention, and control in a society as an indispensable element of basic health services.

The “Health for All” targets of the World Health Organization aim to provide individuals with education that enables them to take responsibility for the protection and development of their health during their lifetime [3,4]. Health education, which offers structured opportunities for learning, includes, in part, communication approaches designed to promote health literacy practices, such as the increase of knowledge levels and the development of life skills to help improve individual and community health [5]. Health care education is not strictly provided through information sharing, but rather is also related to motivation, the encouragement of certain skills and trust, all of which are instrumental for bringing improvement to people’s health [6,7]. It is of paramount importance that health care professionals who work in primary health care institutions have the requisite knowledge, experience, and skills to promote health and to inform society through counselling about proper health-promoting lifestyle behaviours [8,9]. Considering that the key function of health promotion efforts is to strengthen individuals, and in turn, society, it is important that an examination be made of the implementation of health education skills and the role of the health service providers in family health centres, the first point of contact individuals have in the health care system [10-13].

The aim of this study is to determine the health promotion and healthcare training skills of healthcare professionals working in the field of primary healthcare services and their requirements.

METHODS

A descriptive research design was used in the study. The study population consisted of the healthcare professionals working in all family health centres located in the Yenimahalle district of Ankara province. The sample selection was not performed. The research group consisted of 144 healthcare professionals working in 33 different family health centres.

Data collection and analysis

The survey form created by the researcher consists of questions on sociodemographic items, such as age, gender, profession, years of professional experience and years of experience in the institution, as well as questions on the health education and health promotion skills included in the family medicine specialty education and curriculum from 2008.

The data obtained from the questionnaire, conducted in the field, were represented as numbers and percentages. In biostatistical analysis, a chi-square test was used between descriptive statistics and variables, and description and comparison results were presented in tables. $p < 0.05$ was considered as statistically significant. For this study, power analysis was calculated using G-Power 3.1. Under ideal conditions for an observed effect of 0.15, α of 0.05, desired power of 0.95, and an approximate sample size of 144 was needed. Ethics approval was provided by the Hacettepe University non-invasive ethical committee and Turkey ministry of health. Each participant provided informed consent to participate in the study and were made aware that results from the study would be disseminated and published.

RESULTS

The research group consisted of 144 healthcare professionals. Of the 144 healthcare professionals, 94 were nurses and 50 were physicians. The mean age of the participants was found to be 40 ± 6.9 . Approximately half of the participants (43.8%) had an education level lower than a bachelor's degree, and 66.7% had been working for between 17 and 36 years. The mean number of years of professional experience was determined to be 18.5 ± 6.4 , with the mean number of years the participants had been working at their institution found to be 4 ± 4.4 (Table 1).

Table 1 Demographic characteristics of health professionals

Variables	Characteristics	n	%
Gender	Female	122	84.7
	Male	22	15.3
Professions	Physicians	50	34.7
	Family Health Personnel	94	65.3
Years of Professional Experience	1-7 year	9	6.2
	8-14 year	27	18.8
	15-21 year	55	38.2
	22-36 year	49	36.8
Total		144	100.0

This study found that of the healthcare professionals, 34% do not provide healthcare training, 33.3% often provide healthcare training, and 32.6% sometimes provide healthcare training to their patients. The subjects of healthcare training can be categorized as nutrition (46.5%), personal hygiene (39.6%), at-risk groups (36.8%), and use of potentially harmful substances such as tobacco and alcohol (33.3%) (Table 2).

Table 2 Health education practices of health professionals

Variables	Characteristics	Physician		FHP		Total	
		n	%	n	%	n	%
Health Education Practices	No	16	33.3	32	34.4	48	34
	Yes	13	27.1	34	36.6	47	33.3
	Sometimes	19	39.6	27	29	46	32.6
The Content of Health Education	Nutrition Education	14	9.7	53	36.8	67	46.5
	Hygiene	16	11.1	41	28.5	57	39.6
	Risky Group Trainings	16	11.1	37	25.7	53	36.8
	Sexual health	11	7.6	36	25	47	32.6
	Infectious diseases	8	5.6	35	24.3	43	29.9
	Smart Drug Use	15	10.4	22	15.3	37	25.7
	Mouth and dental health	9	6.3	27	18.8	36	25
	First aid and accident	12	8.3	24	16.7	36	25
	Physical activity	14	9.7	19	13.2	33	22.9
	Environmental Health	4	2.8	18	12.5	22	15.3
	Employee Health	8	5.6	10	6.9	18	12.5
	Safe Behaviors	3	2.1	7	4.9	10	6.9
Health Literacy	3	2.1	5	3.5	8	5.6	

In terms of healthcare training skills, this study found the rate of determining, on a relatively frequent basis, the needs of patients to be 60% among physicians and 64.7% among family health personnel (FHP). Among physicians, 75.6% informed patients/their relatives about the diagnosis, treatment, and adverse effects of medication, and that rate was 59.5% among family health personnel. Also, among physicians, 75% informed the patients in occurrence of an acute disease within a short time, and that rate was 53.6% among family health personnel.

Table 3 Health education skills of health professionals

Variables	Characteristics	Rarely		Often	
		n	%	n	%
Determining on a relatively frequent basis the needs of patients	Physicians	18	40	27	60
	Family health personnel	30	35.3	55	64.7
Specific education regard as to patient level and cultural features	Physicians	18	41.9	25	58.1
	Family health personnel	29	34.5	55	65.5
Inform patients/relatives about diagnos. treatment. and effects	Physicians	11	24.4	34	75.6
	Family health personnel	34	40.5	50	59.5
Inform patients in acute diseases within a short time	Physicians	11	25	33	75
	Family health personnel	39	46.4	45	53.6
Long-term planning in chronic diseases	Physicians	22	50	22	50
	Family health personnel	50	59.5	34	40.5
Encourage patients to ask questions	Physicians	10	22.2	35	77.8
	Family health personnel	20	23.5	65	76.5
Using audio-visual education materials	Physicians	25	55.6	20	44.4
	Family health personnel	44	53	39	47

Moreover, this study found that among the physicians, 77.8% encouraged patients to ask questions, and that rate was 76.5% among family health personnel (Table 3). The rate of determining the health risks of individuals who asked advice from healthcare professionals was 56.3% among physicians and 56.5% among family health personnel. Among physicians, 56.3% determined the readiness of individuals for behaviour change, and that rate was 54.3% in family health personnel. This study also found the rate of ensuring that patients participate in their treatment planning was 72.9% in physicians. The rate of enabling behavioural change among adults was found to be less than optimal, both in physicians (50%) and in family health personnel (62%) (Table 4).

Table 4 Health promotion practices of health professionals

Variables	Characteristics	Rarely		Often	
		n	%	n	%
Determining the health risks of individuals	Physicians	21	43.8	27	56.3
	Family health personnel	52	56.5	40	43.5
Determining the readiness of individuals for behavior change	Physicians	21	43.8	27	56.3
	Family health personnel	50	54.3	42	45.7
Participating patients in their treatment planning	Physicians	13	27.1	35	72.9
Adult Behavioral Change Practice	Physicians	24	50	24	50
	Family health personnel	57	62	35	38
Answer patients questions about topics other than examination	Physicians	24	50	24	50
	Family health personnel	60	66.2	32	34.8
Understandable education messages	Physicians	19	40.4	28	59.6
	Family health personnel	46	50	46	50
Effective communication with health team	Physicians	25	54.3	21	45.7
	Family health personnel	48	55.2	39	44.8

A statistically significant difference was found between the degree to which the practitioners had put their health education skills into practice and the level of education they had received beforehand. In relation to this finding, there was a significant difference between the physicians and nurses who had received health promotion education beforehand versus those who had not, in terms of their abilities to determine the health risks of their advisees ($p < 0.05$) to identify whether their advisees were ready for behavioural change ($p < 0.05$) to administer adult behavioural change to their advisees ($p < 0.01$) to answer their advisees' questions about topics other than those related to the examination ($p < 0.01$) to communicate understandable education messages ($p < 0.01$) and to effectively communicate with the health team in activities performed for health promotion ($p < 0.01$). The degree to which the health care skills were put into practice by the health care personnel who had received health promotion education was found to be higher than that of those who had not received such education beforehand (Table 4).

Table 5 Obstacle factors of health professionals in health care practice

Variables	Characteristics	Physicians		FHP		Total	
		n	%	n	%	n	%
Opinions about obstacle factors	Yes	44	88	70	74.5	114	79.2
	No	6	12	24	25.5	30	20.8
	Total	50	100	94	100	144	100
Obstacle factors	Fatigue	16	11.1	16	11.1	32	22.2
	Financial inadequacy	10	8.3	14	15.7	24	16.7
	The lack of staff	24	16.7	33	22.9	57	39.6
	Time Limitation	38	26.4	56	38.9	94	65.3
	Lack of information	4	2.8	8	5.6	12	8.3
	Communication problems	17	11.8	13	9	30	20.8
Inter-Institutional Communication	19	13.2	13	9	32	22.2	

Table 5 presents the distribution of the health care personnel's opinions about the presence of institutional barriers. The percentage of those who believed that there were barriers against them within the institution they worked was found to be 79.2%, with the most significant barrier being reported as time constraints (65.3%). Among other barriers reported, the lack of personnel and finance ranked second with a percentage of 39.6% (Table 5).

Results from the study found that approximately one-third of the participants, a relatively low figure, planned to provide health education (33.3%). No statistically significant relationship was determined between the rates of receiving and providing education for health promotion. However, the individuals who had received education for health promotion were expected to engage in more education planning. In terms of the education practices planned to be provided by the health care personnel, 46.5% had planned nutrition education, 39.6%, personal hygiene and 36.8%, education practices for risk groups. In a study by Tomasik, et al. examining the education requirements and experiences of family

physicians in health promotion, it was observed that physicians primarily provided education in the areas of infant and maternal health, lifestyle, and environment [14]. A study conducted by Whitehead, et al. on nurses' perceptions of health promotion and health education found that education was generally based on exercise, nutrition, and mental health [15]. The present study determined that the frequency in which mental health education was provided was quite low, with a rate of 14.6%. This result was believed to be due to the organization of community education practices by community mental health centres. The frequency in which physical activity education was provided, on the other hand, was 22.9%. Considering that obesity was reported to be included in the priority programs, it would have been expected that the health care professionals provide more education practices for nutrition and physical activity. The present study found that among the physicians, 63% could frequently determine the requirements and priorities of the patient. In a study conducted by Ashbury, the rate at which the patient's psychological, mental, and social needs were evaluated was found to be 52.5% [16]. Although the rate for the same measurement in the present study was higher, it was observed that there was a substantial number of people whose individual needs and priorities were not taken into consideration.

In the present study, 75.6% of the physicians and 59.5% of the family health personnel reported that they were frequently able to inform the patient by giving clear explanations. In Ashbury's study, the percentage of physicians who were sure that they had explained the treatment plan in a comprehensible manner was found to be 99.6%. In that same study, the percentage of physicians who were sure that they had helped the patient cope with the existing health problem more easily by giving comprehensible explanations was found to be 98.8%.

The percentage of physicians with this ability to inform patients about diagnosis, treatment and adverse effects was found to be lower in the present study. Among the basic principles of medical ethics, respect for autonomy is one of the most important, as it stipulates that patients be given comprehensible information and be involved in the treatment options about their situation [17]. Approximately half of the family health personnel stated that they were only rarely able to provide patients with information. Modern nursing practices, which require that nurses be capable of providing information, education and counselling, are not thought to be actively used in providing first-step health services. It is clear, however, that in the case of acute diseases, family health personnel should take more steps to provide individuals with information and help them cope with the current situation [18].

This study also found that the rate of frequently making long-term and gradual change of behaviour plans among physicians (50.0%) was less than their rate of informing patients within a short time (75%). The rate of enabling individuals to obtain information and cope with their current situation in occurrences of acute disease was 53.6% among family health personnel. This percentage indicated that the family health personnel should be better trained in healthcare training skills.

Although family health centres are of key importance in terms of preventing chronic diseases, almost half of the healthcare professionals (50.0% of physicians and 40.5% of family health personnel) stated that they could not make long-term plans for their patients. This result emphasizes that the effectiveness of healthcare personnel should be assessed regarding their ability to plan for the prevention and treatment of chronic diseases. Interpersonal relations and exchange of information are important for participation in an effective treatment plan. By evaluating the patients' learning needs and whether they are ready for learning can help to ensure that they are aware of their autonomy. This evaluation, which should include assessment of the patient's knowledge, understanding and beliefs to learn the underlying causes of their behaviours, will help to secure a more effective achievement of goals, as far as it will help to reveal any wrong attitudes and perceptions held by the patients and ultimately support them in cultivating healthy behaviours. Published studies have shown that there is a relationship between the encouragement offered by the healthcare personnel to their patients and the patients' ability to ask questions [19,20].

The present study shows that most of the participants stated that they regard the needs of patients limited only to the diagnosis and treatment of disease; the requests and expectations of patients such as obtaining information, finding answers for their questions, receiving solace, and getting rid of the symptoms should be also taken into consideration. It is clear from the present results that healthcare professionals should further develop their knowledge, experience, and skills in terms of assessing the health risks of patients. In a study conducted by Haley, et al. approximately 40% of the family physicians reported that the medical education they had received was adequate for performing risk assessments of patients [21]. Clearly, health care personnel should be evaluated to determine their risk assessment knowledge, experience, and skill.

The most basic method for encouraging individuals to adopt healthy behaviours is to first identify whether they are ready for behavioural change. In a study conducted in the Netherlands by Helakorpi, et al. with physicians who worked in home care services, general practitioners determined that 24% of the patients, on average, were ready for behavioural change in the areas of smoking, diet, and physical activity [22]. In the present study, this percentage was found to be higher.

The most fundamental method of enabling individuals to develop healthy behaviour is to determine their readiness for behavioural change. That would enable healthcare professionals to better understand the perceptions of patients concerning their present behaviour and their motivations for behavioural change in the future. In terms of enabling adults to change their behaviours, half (50%) of the physicians and 38% of the family health personnel reported that they could enable adults to change their behaviour. The results obtained from the healthcare professionals in terms of determining the readiness of individuals for behavioural changes and enabling adults to change their behaviours were found to be similar. Consequently, healthcare professionals should increase their role in providing information and motivation to encourage adults to change their lifestyle. Among the physicians, 72.9% were able to ensure patients' participation in the treatment plan. Ashbury, et al. reported that 93.8% of the physicians in their study ensured the involvement of patients in the decisions for their treatment and that 76.3% informed the patients about the treatment and its options [16]. These percentages were found to be lower in the present study.

One of the fundamental rights of patients, as specified in the patient safety practices put out by the Joint Commission in 2009, is to ensure that patients participate in the decision-making process in their treatment [23]. Positive health outcomes can be achieved through patient adherence to the treatment. Patient non-compliance, on the other hand, can pose a threat to health and relief and lead to considerable economic problems. Although it is not always possible to communicate effectively with patients, addressing the issues of cooperation and various treatment options together is important in terms of fostering respectful and trusting relations with the patients [24]. Consideration should be given to the importance of establishing a therapeutic relation with patients and of entering discussion about the current health status and treatment plan [25]. Half of the physicians and one-third of family health personnel were able to answer questions posed by the patients about topics other than those related to the examination, and 59.6% of the physicians and 50% of the family health personnel reported that they give comprehensible education messages. On the contrary, approximately half of the participants reported that they did not give sufficiently comprehensible education messages. In communicating messages, it is important that the messages are brief and able to express the importance of education to the target audience [26]. The patients' level of understanding and their literacy can also be listed among the other important aspects of education practices that should be taken into consideration in patient education. In the present study, it was shown that one of the barriers to community involvement in health promotion was the low level of health literacy; however, the number of health care personnel who took this case into consideration was not adequate. Less than half of the participants reported that they frequently engaged in effective communication with health team members, such as dietitians and education nurses. The value of teamwork to ensure the provision of effective, high quality education is self-evident, yet from the present study it can be concluded that little to no coordination for fostering effective communication was facilitated between family health staff and health team members.

CONCLUSION

In conclusion, the present study found that the healthcare training and health promotion skills of healthcare professionals were in general not at acceptably high levels. Nurses should be more active in patients' healthcare training, which is one of their contemporary roles. Considering that insufficient personnel and intense workload hinder healthcare professionals in performance of their present roles, it is recommended that personnel planning and workload distribution should be made more effective. Also, the duties and responsibilities of nurses in terms of providing training and counselling services, which are included in their contemporary roles, should be made more active and visible in the future.

In the present authors' opinion, turning healthcare professionals' practice of determining the readiness of individuals for behavioural change into an application enabling recording will make a positive contribution to their health promotion outcomes. The notion that current procedures are adequate for health improvement practices in comparison with requiring therapeutic practices only is another issue to be addressed. The way should be paved to enable nurses who receive public health education, particularly at the advanced level that includes science expertise and doctoral studies, to use their coordinating and leading skills to contribute to the first-grade healthcare services. The present

authors recommend a thorough examination of the importance of primary healthcare services concerning practices that involve health protection, promotion of good health behaviour, and that the family health centre personnel's knowledge, experience, and health promotion skills and healthcare training.

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